Daily Screener

By submitting this form, I certify that the information I am providing is true and correct.

First name _____ Last name _____

Job title _____ Location _____

Supervisor _____

Activity for which you are screening/Reason for visit:

- O Human Resources Orientation
- O Daily entrance to work
- O Scheduled or unscheduled meeting with _____

In the past 14 days, have you had known, prolonged (>10 minutes) close contact (within 6 feet) with a person who has tested positive for COVID-19 or is suspected of having COVID-19?

O Yes O No

In the past 24 hours, have you had any of the following new or worsening symptoms?

- Cough
- Shortness of breath or difficulty breathing
- Chills/repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- Loss of taste or small
- Diarrhea
- Feeling feverish or a measured temperature greater than or equal to 100.0 F

O Yes O No

_____Please list the temperature taken at home

Or

_____List the temperature taken at entrance of building

Signature _____

Date _____